No. 95-1858
No. 96-110

IN THE

SUPREME COURT OF THE UNITED STATES

October Term,1996

DENNIS C. VACCO, Attorney General
of the State of New York,
GEORGE PATAKI, Governor of the State of New York
ROBERT M. MORENTHAU, District Attorney
of New York County

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D.,
and HOWARD A. GROSSMAN, M.D.

Respondents.

On Writ Of Certiorari To The U.S. Court Of Appeals For The Second Circuit

STATE OF WASHINGTON, AND CHRISTINE GREGOIRE
Attorney General of the State of Washington

Petitioners,

v.

HAROLD GLUCKSBERG, MD., ABIGAIL HALPERIN, M.D.,
THOMAS A. PRESTON, M.D. and PETER SHALIT, M.D., Ph.D.

Respondents

On Writ Of Certiorari To The U.S. Court Of Appeals For The Ninth Circuit

BRIEF AMICUS CURIAE OF THE INTERNATIONAL ANTI-EUTHANASIA TASK FORCE IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

May a State protect its residents by prohibiting assisted suicide?

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STATEMENT OF INTEREST

The International Anti-Euthanasia Task Force (IAETF) is the trade name of the Family Living Council, a non-profit corporation formed in 1976 to provide education in matters related to family life, health and related matters. The IAETF, with networkers throughout the world, addresses the medical-ethical issues of death and dying, health care delivery, the rights of the terminally ill, the chronically ill, the elderly, persons with disabilities and their families. Involvement of the IAETF in such matters includes education, advocacy, consultation, legislative analysis and networking. The IAETF is a major resource for individuals and groups seeking information about the rights of medically vulnerable individuals and their families.

This *amicus curiae* brief has been filed with consent of the parties. Letters of consent were filed with this brief with the Clerk of the Court.

SUMMARY OF THE ARGUMENT

The matter at bench is one of the most important constitutional challenges ever to face this Court. At stake is the determination of the very organizational purpose for which our society, under law, exists.

This Court will decide whether the state's foundational role as protector of the lives of all of its citizens is consistent with existing constitutional principle and the law, or whether this traditional state responsibility will be superseded and replaced by new and radical constitutional notions which prohibit states from protecting their citizens and, further, force states to countenance and facilitate the deliberate ending of human lives under the guise of compassion, elimination of suffering, and exercise of individual rights.

The current question before the Court is not whether dying patients have the right to end their suffering, as Respondents argue. (Certainly, the ending of suffering is a laudable goal and, if that were the real issue, there would be no controversy.) Rather, the issue before this Court is whether states

have the right to protect weak and vulnerable individuals as well as the greater societal good by prohibiting assisted suicide.

Strong emotional arguments are made by Respondents who seek to have this Court decide that existing state laws which proscribe assisted suicide are unconstitutional. Proponents of this radical theory of constitutional jurisprudence claim that the state has little or no legitimate interest in prohibiting assisted suicide because the assisted suicide of patients would permit them to determine "the time and manner of one's own death"[1] and would be used as " a treatment of last resort,"[2] to take place only after people have exhausted all treatment and comfort care possibilities.

As this brief will demonstrate, such conclusions and arguments are facile, designed as a veneer to deflect the Court's attention from the context in which legalized assisted suicide would be practiced. This brief argues that assisted suicide, as it would take place in the "real world," demonstrates both the rational and vital state interests promoted by state laws which currently outlaw assisted suicide.

The "last resort" claim is based upon the false premise that virtually every American citizen or resident has access to wanted medical treatment and necessary health care. Further, it mistakenly assumes that all necessary time and health care resources would be at the disposal of each suicidal patient prior to any implementation of physician facilitated death.

The reality of the United States health care delivery system belies these soothing assurances. An increasing number of people are experiencing great difficulty in obtaining necessary medical services, in part because of the ongoing transition from "fee for service" medicine to "managed care." In such a milieu, this brief argues, assisted suicide would be especially dangerous.

Managed care systems often have financial incentives which impose conflicts of interest between patients and their

1. *Compassion in Dying v. Washington*, 79 F.3d 790, 793 (9th Cir. 1996).

2. F. Miller, T. Quill, et al, *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119,120 ((1994).

own doctors. These conflicts create the potential for denial of wanted and needed medical care based on pecuniary, rather than medical, considerations. In turn, the suffering caused by denied or delayed care can create a desire for assisted suicide.

The "medical practice" of assisted suicide would not be implemented in a vacuum. There is nothing to indicate that a judicially created transformation of assisted suicide from a crime into a legitimate form of medical treatment would cause the health care delivery system to become more responsible to patient needs, nor would it afford a compassionate means for patients to have their suffering alleviated. If anything, the availability of assisted suicide would likely result in a decreased amount of time and attention given to treating and alleviating significant medical problems, such as pain, particularly when assisted suicide would be far less time-consuming and less costly than interventions which alleviate pain while not taking the patient's life. This latter point is especially pertinent in a health care system dominated by managed care.

It is within the context of the growing managed care system of health delivery and the growing prominence and influence of for-profit health maintenance organizations (HMOs) that the far reaching implications of striking laws which prohibit assisted suicide must be considered. Considering the financial implications of legalizing assisted suicide as it relates to proper patient care, a state not only has the right but the positive responsibility, to protect its citizens by prohibiting assisted suicide.

I. IN STRIKING DOWN STATE LAWS PROHIBITING ASSISTED SUICIDE, THE SECOND AND NINTH CIRCUITS FAILED TO ADEQUATELY CONSIDER THE ECONOMIC PRESSURES THAT WOULD FORCE INDIVIDUALS TO ACCEPT ASSISTED SUICIDE.

The Second Circuit Court in *Quill v. Vacco*[3] erroneously disregarded the importance of the significant economic and psychological pressure that would be placed on individuals if states were barred from prohibiting assisted suicide. In strik-

3. *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996).

ing down New York's laws against assisted suicide, the Second Circuit nonchalantly suggested that any such pressures could be alleviated by state formulated guidelines: "In any event, the state of New York may establish rules and procedures to assure that all choices are free of such pressures."[4] Not only did this suggestion totally ignore the carefully drafted report of the New York State Task Force on Life and the Law,[5] which clearly outlined and documented the peril in which citizens would be placed if assisted suicide were permitted, even under guidelines intended to be protected, it also failed to take note of the reality of the current state of the health care delivery system.

Likewise, the Ninth Circuit, in concluding that state laws against assisted suicide are unconstitutional, paid little attention to this reality.

After a cursory acknowledgment that economic factors and lack of adequate health care may well influence an individual's decision to die by assisted suicide, the Ninth Circuit fastidiously decided to "stand aside from that battle."[6] The Court implied that, if assisted suicide were not available to those who are already injured by the lack of access to adequate health care, they would be further harmed: "On the other hand we are certainly not obligated to pile injury upon injury. . . ."[7]

In fact, by removing the states' rights to protect vulnerable citizens from the considerable economic pressure to die and get out of the way, the Second and Ninth Circuits did pile injury upon injury. In concluding that states should not be able to prohibit assisted suicide, both courts sent a bold message that access to death-producing medical intervention is a constitutional right, but access to life saving or life enhancing medical intervention is not.

4. Id, at 730.

5. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994).

6. Supra note 1, at 826.

7. Id.

II. IN DETERMINING WHETHER STATES HAVE BOTH A VITAL AND RATIONAL INTEREST IN PROHIBITING ASSISTED SUICIDE, THIS COURT MUST CONSIDER THE IMPACT OF MANAGED CARE ON THE CONTEXT IN WHICH ASSISTED SUICIDE WOULD BE CARRIED OUT.

A. Managed Care Has Changed the Very Basis upon which Health Care Is Provided.

In an effort to control unnecessary medical costs and improve the efficiency of health care, a transition of monumental import is currently taking place in the health care system. This transition is from a traditional "fee-for-service" system to a "managed care" system of health care delivery.

Under the fee-for-service system, health providers were paid for each service performed. This sometimes led to patients' being overtreated and subjected to interventions that were futile. In the fee-for-service system, health providers had a financial incentive to exhaust all treatment possibilities or provide unnecessary care since the more treatment that was given, the greater was a provider's income.

Managed care operates in a manner that is almost a reverse of the fee-for-service system. Under managed care, health providers are encouraged by a myriad of incentives and disincentives to control costs by *limiting* treatment and care. Health care professionals now find that their incomes, in large part, depend upon providing fewer, not more, services.

While there is nothing inherently wrong with the concept of managed care, nor with the attempt to appropriately control health care costs, managed care, as it presently operates, has caused enormous problems: "Prodded by large companies fed up with rising medical costs, the new medicine's entrepreneurs have turned health care into a corporate battlefield increasingly governed by the promise of stock market wealth, incentives that reward minimal care and a brand of aggressive competition alien to front-line doctors. . . ."[8]

8. Larson, *The Soul of an HMO*, Time, Jan. 22, 1996, at 45.

The usual and traditional presumptions about health care financing and delivery have been turned inside out, and its effects are being felt by millions of people.

In 1995 up to 130 million people were in some type of managed care program.[9] Among American workers who are covered by health insurance, seventy-one percent are in managed care programs[10] and, according to the Health Care Financing Administration's Office of Managed Care, eighty thousand Medicare beneficiaries are being transferred each month from traditional fee-for-service health plans into managed care programs.[11]

The number of physicians affected by the growth of managed care is also increasing rapidly. Whereas physicians used to be self-employed and, thus, were ultimately in charge of how much time they spent with patients and how much care they wished to provide for a certain fee, more and more doctors are now becoming employees who are subject to control by managed care organizations. According to the American Medical Association, only slightly over half of doctors remained self-employed by 1995.

Indicative of the new way in which medicine is practiced is the terminology now used in conjunction with medical care. Provider-consumer business terminology has largely replaced references to what was formerly called the physician-patient relationship. Such business oriented designations have caused grave concern among physicians.[12]

The agreements used in that provider-consumer relationship have undergone such a significant transformation that the meanings of commonly used words and phrases may now mean something far different to the consumer than they do to

9. D. Blumenthal and S. Thier, *Managed Care and Medical Education*, 276 J.A.M.A. 725 (1996).

10. Myerson, *Executives Are Cradled while Medicaid Benefits Are Cut for Rank and File*, N.Y.Times, March 17, 1996, at 1, 13.

11. Johnsson, *Managed Care Fraud*, Am. Med. News, May 20, 1996, at 3, 26.

12. See, e.g., J. Olivero, *Why "Providers" Instead of Physicians?*, 156 Arch. Inter. Med. 2148 (1996).

the provider.[13] Additionally, this consumer-provider construct bears striking similarity to one which is contractual in nature. In a contractual relationship, however, there is generally some type of parity as it relates to information. That parity is lacking in the medical realm under managed care. It is the provider who has virtually all of the information. It is the provider who may withhold information on the basis of possible benefit or potential harm to the provider. It is the consumer who often does not have adequate information, because the provider has withheld it.

This presents a clear conflict for physicians and increases the possibility of grave harm to patients, a matter clearly relevant to the matters before the Court. If states were prohibited from banning assisted suicide, patients who were denied full access to information about the availability of treatment could be led to believe that assisted suicide was their only remaining option.

B. Managed Care Programs Use a System of Financial Incentives and Disincentives which Impose Conflicts of Interest between Patients and Their Doctors.

Under the doctrine of informed consent physicians have a common law duty to provide patients with all information that is material to that patient's treatment decisions. This duty encompasses informing patients about all reasonable treatment alternatives, and the risks and benefits of each, regardless of cost.[14]

Additionally, a patient has the right to be told about financial incentives that may exist to induce physicians to manipulate the range of options offered to the patient. The physician has an obligation to "disclose personal interests

13. See, e.g., R. Marker and W. Smith, *The Art of Verbal Engineering*, 35 Duq. L. Rev. 81 (1996).

14. *Cobbs v. Grant*, 8 Cal. 3d 229 (1972).

unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment."[15]

Despite the existence of clear requirements for such disclosure, managed care programs have created barriers between physicians and patients which threaten a patient's right to receive complete and accurate information and which compromise the professional responsibility of physicians. These barriers arise from a combination of factors: a method for health services payment referred to as "capitation," a combination of financial incentives and disincentives, and the existence of what are called "gag rules" in managed care contracts.

These approaches, used by managed care organizations, hold down costs by controlling physicians' fees and limiting patients' access to services. They could be accurately described as a "carrot and stick" method which compensates physicians in direct proportion to how little they do for patients.

Under the "capitation" approach, the managed care organization pays a flat fee per patient per month to a physician or group of physicians. For example, under one managed care plan, physicians receive $8.43 each month for every male patient between the ages of twenty-five and forty-four and $10.09 per month for each female patient between the ages of twenty and twenty-four.[16]

15. *Moore v. Regents of the University of California*, 793 P. 2d 479, 271 Cal. Repr. 146 (1990).

16. *Compromising Health Care*, Wash. Post, June 16, 1996, at C8. At the same time that doctors and other health professionals are being pushed to see more and more patients for less and less pay, and as patients are often being denied needed treatment, it is estimated that profits of twenty to thirty percent are going into the pockets of investors. In 1995, the total compensation package of the typical health care corporate CEO was close to $2.9 million. Auerbach, *As the Marketplace Changes, Consumers Are Caught in the Middle*, Wash. Post, June 25, 1996, at Z12. Several earned between $8.8 and $15.5 million per year. Freudenheim, *Health Chief's Big Paychecks for Chopping Costs*, N. Y. Times, Apr. 11, 1995. That does not take into account stock dividends paid to investors.

In return for the monthly fee per patient, the physician is to provide all medical services (subject to the terms of the managed care contract) for each covered patient. These services generally include primary care, specialty care, hospitalization, prescriptions, and a broad range of other health care services. If, during any given month, the actual cost of care for the covered patients is lower than that of the fees paid, the doctor retains the excess. If, however, the actual cost of care exceeds the fees, the health provider loses money. The possibility of losing money by providing care can be a powerful incentive to deny even needed care.[17]

Another cost control method, often coupled with capitation, depends upon what is referred to as a "withhold" in which the managed care organization withholds a percentage of the per patient fee that would ordinarily be paid to the physician. At the end of a certain period of time, the managed care program reviews the physician's practice and determines whether the physician should receive any of the withheld fees. If the managed care program determines that the physician is spending too much time per patient or that he or she is ordering too many diagnostic tests or providing too much treatment, the managed care organization retains the withheld fee. Amounts withheld in this manner vary from a low of eleven percent (withholds of less than eleven percent have been found ineffective as an incentive for physician's to limit services and referrals) to more than thirty percent.[18] Even when income is not withheld, some managed care organizations place a lien on future earnings or reduce the capitation fee as a means of penalizing a physician's failure to meet the fiscal expectations and requirements of the managed care program.[19]

According to data compiled in 1995 by the American Medical Association, one-third of doctors have capitated com-

17. See generally: Freudenheim, *Health Care in the Era of Capitalism*, N.Y.Times, Sept. 4, 1996, at 6E; and T. Bodenheimer and K. Grumback, *Capitation or Decapitation*, 276 J.A.M.A. 1025 (1996).

18. E. Morreim, *Balancing Act: The New Medical Ethics of Medicine's New Economics*, 35 (Georgetown University Press, 1995).

19. Id.

mercial contracts, and forty-eight percent are subject to some method of fee withhold. For doctors who have such contracts with manage care programs, nineteen percent of their income is attributed to capitation accounts.[20]

The wedge that such financial incentives and disincentives places between patients and doctors is intensified by another provision, referred to as a "gag rule," that is contained in many contracts between managed care organizations and physicians.

C. Managed Care Programs Have Created Barriers between Physicians and Patients which Violate Patients' Rights to Receive Complete and Accurate Information about Their Health Care.

Doctors who sign managed care contracts that have gag rules are prevented from providing often essential information to patients. Some gag clauses forbid a doctor from telling a patient about treatment options until the plan approves the specific treatment for that patient. Other programs prevent a doctor from telling a patient that a beneficial treatment that is not covered by the program is available elsewhere.

Under the gag clause provisions doctors say they cannot talk freely to patients about either their treatment options or about the particular managed care program's payment policies. They are even forbidden to tell patients that doctors who save money by withholding care get financial bonuses.[21]

Gag clauses also prohibit informing patients about outside "gatekeepers."

For example, one managed care organization sent a notice to physicians under contract with its program stating, "Do not discuss proposed treatment with [the managed care program's] members prior to receiving authorization" and further directed doctors to avoid discussing the procedures that must be followed to obtain such authorization[22]

20. Johnsson, *Trial Focus: Public Unease with Physician Incentives*, Am. Med. News, Aug. 12, 1996, at 1, 34.

21. Pear, *Doctors Say H.M.O.'s Limit What They Can Tell Patients*, N.Y. Times, Dec. 21, 1995, at A1.

In many managed care programs, it is the primary care physician who serves as the gatekeeper. Physician gatekeepers may come under considerable pressure to deny access to services as evidenced by a warning, given by one managed care organization to physician gatekeepers in its program, stating that the physicians' contracts would be terminated if they approved too many specialist referrals. [23]

Other programs rely on outside gatekeepers (who may be physicians, nurses or persons who are not trained in medicine). Outside gatekeepers may be located in a different city or state and have no personal contact with the patient or the patient's primary care physician. This type of gatekeeper or reviewer is often compensated on the basis of cost saving for the managed care organization.

The role of an outside reviewer was described by Dr. Linda Peeno when she testified before the House Commerce Health Subcommittee. Dr. Peeno, who had served as a medical reviewer for a managed care program, said she saved her employer money by denying treatment. She explained that, in one such case, her decision led to a man's death but, rather than being held accountable, she was financially rewarded. She earned an annual six-figure income by using her medical expertise to bring financial gains to the organization. "According to the managed care industry, it is not an ethical issue to sacrifice a human being for a 'savings,'" she said.[24]

D. To Preserve a Competitive Edge in the Marketplace, Managed Care Organizations Resist Attempts to Assure Patients' Rights.

Until very recently, health institutions, both public and private, were overwhelmingly non-profit endeavors. However,

22. Id.

23. Reuters Health News Service, *HMOs Respond to Member Complaints*, Aug. 20, 1996.

24. Gianelli, *Congress Considers Ban on Managed Care "Gag" Clauses*, Am. Med. News, June 19, 1995, at. 5, col. 1.

for-profit organizations are becoming the rule, rather than the exception, so that more than seventy percent of all HMOs are now for-profit corporations. With this change has come a shift in focus. Within the non-profit realm, any excess money is earmarked to improve services, access and care for the served population. In the for-profit sphere, money saved by limiting services benefits corporate shareholders. Meeting profit projections supplants meeting patient needs and is the driving force in the for-profit arena.

It would seem reasonable to assume that if patients demand types of care that may increase costs, managed care programs would respond since pleasing the customer has always been considered good business practice. The program could then pass on the costs to the consumer by raising premiums. However, this assumption misses a crucial point. In most cases, employers, not individual subscribers, pay the premiums, so they are the customers who must be pleased. Further, it is the employer, seeking to keep expenditures for employee benefits down, who will opt for a program that keeps rates down.

In 1995, a broad coalition of patient and provider groups drafted a set of standards on the rights of patients, including the right to information about provider incentives or restrictions that might influence practice patterns. Managed care organizations refused to sign on. Although the principles were endorsed by over one hundred groups including the American Medical Association, American Cancer Society, American Association of Retired Persons, and the Joint Commission on Accreditation of Health Care Organizations, a managed care representative explained that the principles seemed to be "too close to the operational issues" of managed care.[25] A subsequent attempt to adopt government regulations restricting managed care organizations' practice of incentives and gag rules was successfully resisted by managed care programs. The

25. Page, *Managed Care Firms Balk at Patient Rights Agreement*, Am. Med. News, Dec. 4, 1995, at 3, 23.

managed care industry claimed that such practices are important in "a fast-moving, intensely competitive industry."[26]

With their sites firmly on profit margins and beating the competition, it seems reasonable to predict that managed care corporations would be more than willing to reimburse for inexpensive assisted suicide services that would eliminate the need for some costlier services.

E. Denial of Emergency Care which Often Occurs as a Result of Managed Care Can Create the Very Conditions that May Lead to Assisted Suicide.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to provide "a standard medical screening evaluation"[27] to anyone who goes to an emergency room requesting care. In addition, the hospital must give any treatment that is necessary to stabilize the patient's condition, making use of all necessary and routinely available facilities of the hospital to reach a diagnosis that rules out the presence of a legally defined emergency medical condition.[28]

Emergency physicians are well aware that any delay in emergency care while seeking to obtain authorization for payment may be detrimental not only for the patient but may result in liability for the hospital.[29] However, managed care organizations and clinics run by health maintenance organizations are not within the scope of these requirements since "the plain wording of the statute makes reference only to 'hospitals' and shows legislative intent to provide emergency medical treatment by hospitals to all individuals."[30] Managed care organizations escape responsibility under EMTALA because they are only authorizing payment, not treatment.

26. Pear, *U.S. Shelves Plan to Limit Rewards to HMO Doctors*, N.Y.Times, July 8, 1996.

27. 42 USC 1395 dd (a).

28. 42 USC 1395 dd (b).

29. 42 USC 1395 dd (h). See, e.g., *Griffith v. Mount Carmel Hospital*, No. 92-1141-MLB, (D. Kan. Aug. 23, 1993).

30. *Dearmas v. Av-Med Inc.*, 814 F. Supp. 1103, 1108 (S.D. Fla. 1993).

Although, technically speaking, the managed care organizations cannot deny authorization to receive emergency treatment,[31] managed care policies do operate to block emergency room care by denying payment if pre-authorization is not obtained. Thus, a clear conflict exists between federally mandated medical screening examinations and the pre-authorization processes that are required by most managed care organizations. "Managed care requirements that patients be pre-authorized for emergency department visits or admissions are totally inconsistent with and unregulated by EMTALA."[32]

Emergencies are, by definition, unexpected and difficult to manage. Obtaining pre-authorization in an emergency situation can result in loss of time and loss of life. Nonetheless, managed care programs continue to require pre-authorization. As one members' handbook stated (in fine print), "Failure to contact the primary care physician prior to emergency treatment may result in denial of payment."[33]

According to Dr. Charlotte S. Yeh, chief of emergency medicine at the New England Medical Center in Boston, "In some ways, it's less frustrating for us to take care of homeless people than HMO members. At least we can do what we think is right for them, as opposed to trying to convince an HMO over the phone of what's the right thing to do."[34]

Such inconsistencies can place patients at risk and may force emergency room physicians to choose between providing necessary medical care or facing loss of hospital privileges for providing care that may not be reimbursed. In a survey of 1,047 board-certified emergency physicians, 18.6% said "they

31. "Managed healthcare plans cannot deny a hospital permission to examine or treat their enrollees. They may only state what they will and will not pay for, and regardless of whether a hospital is to be reimbursed for the treatment, it is obligated to provide the services specified in EMTALA." HCFA's Rules and Regulations, 59 *Fed. Reg.* 32,116 (1994).

32. S. Frew, *Managed Care, in Patient Transfers: How to Comply with the Law*, (American Academy of Emergency Physicians, Second Edition, 1995)

33. Pear, *HMO's Refusing Emergency Claims, Hospitals Assert*, N.Y.Times, July 9, 1995, at 1,12.

34. Id.

had been threatened or lost hospital privileges because they voiced concerns about quality of care."[35]

At a time when managed care cost containment provisions make even emergency care difficult to obtain, it would be incredibly naive to assume that the same managed care programs would authorize access to all medical options, some of which may be expensive, before approving the cost effective treatment of assisted suicide.

Indeed, managed care programs have consistently resisted providing services which, under fee-for-service, were previously included within even the most basic type of health care coverage. Even after there was tremendous public outcry about so-called "drive through deliveries" – in which new mothers and their infants were sent home from the hospital within hours of birth – many managed care programs maintained their refusal to pay for more than a day of hospitalization. It took federal legislation to require that new mothers and their infants could receive a minimum hospital stay of 48 hours after birth.[36]

It seems reasonable to believe that managed care programs which had to be forced to allow new mothers and infants to receive an additional 24 hours of hospitalization, may be less than willing to permit months of palliative care or great amounts of long term therapy for chronic conditions. This would be particularly true if the same managed care programs could authorize the provision of a lethal prescription as a quick and inexpensive means to "treat" the same condition.

In fact, most managed care organizations fail to provide services which address anything other than short term cost effectiveness.

35. *American Academy of Emergency Medicine Survey Preliminary Report*, Emergency Med. News, August 1995.

36. Veterans Administration.-HUD Appropriations Act of FY 1997, Pub. L. No.104-204, 110 Stat.2874, Title VI, Sec. 601 (Sept. 26,1996).

F. Managed Care Programs Often Operate in a Manner that Indicates a Quest for Only Short Term Effectiveness and Maximum Cost Containment

For medical conditions, like appendicitis or minor infections that can be addressed in the short term, managed care programs do relatively well. Problematic, however, is the care received by people who have conditions that require long term care. Thus, a relatively healthy person who enters into a managed care program will generally be satisfied with the program as long as his or her health remains good overall. If, as often happens, a person develops a condition, like multiple sclerosis, that requires on-going care, managed care often falls short of expectations.[37]

Additionally, while all managed care programs emphasize preventative care, not all have programs to prevent complications that can result from chronic disease. The way in which managed care deals with diabetes is an illustration of the quest for short term cost effectiveness. Fewer that one-half of HMOs have implemented programs to manage diabetes[38] even though more than 14 million Americans are known to have diabetes,[39] which can cause blindness, kidney failure, nerve damage and is the fourth leading cause of death in the United States.[40]

Regimens that could result in greatly reduced costs in terms of patients' lives and health care resources have sometimes been ignored in the interest of immediate monetary saving. When the National Institute of Health (NIH) supported a study on diabetes that showed that good control would reduce the complications of diabetes, managed care organizations indicated a marked lack of interest in the program. According to Dr. Judith Vaitukaitis, director of the National Center for

37. Rosenthal, *Patients Say N. Y. HMOs Don't Deal Well with Complex Illnesses*, N.Y.Times, July 15, 1996, at A19.

38. Reuters Health News Service, *HMO Enrollment Surpasses 59 Million in U.S.*, Oct. 23, 1996.

39. Blakeslee, *Program to Cut Risks of Diabetes Surprisingly Fails to Lure Patients*, N.Y.Times, Feb. 28, 1994, at A1,5.

40. *New Diabetes Treatment May Block Worst Effects*, San Francisco Chron., June 14, 1993, at A3.

Research Resources at NIH, this stance on the part of managed care programs was due to the fact that the managed care organizations did not want to spend the extra time and resources that good control would require. She explained that "the benefit of reduced complications is not seen for years ahead and they [managed care organizations] don't see the benefit in reduced costs because of the rapid turnover of their members."[41]

This emphasis on quick profits has also been described by Dr. George Lundberg, editor-in-chief of the *Journal of the American Medical Association*, who stated, "Getting managed care companies to think in terms of the long term is starry-eyed. Profit is to be made here. The managed care companies are not interested in the long term."[42]

It would seem logical for managed care organizations to promote long term preventative care since this would result in future savings. However, according to health care consultant Theodore J. Weinberg, individuals change health care programs about every three or four years.[43] The advantages of long term preventative measures may not show up for ten years or more and, by that time, a person may be in another managed care program. Consequently, competitive managed care programs are unlikely to invest in outcomes that would not pay off within a short period since the investment in a prevention program paid for by one managed care organization may result in better health (and thus lower expenditures) for enrollees in a competitor's program.

With this short sighted approach to health care, the long term consequence could be greater numbers of debilitated individuals who would create additional strain on the health delivery system. This, in turn, could spur greater incentives for managed care programs to promote assisted suicide as what one euthanasia advocate has called "a new age form of hospice care."[44]

41. C. Marwick, *Effect of Managed Care Felt in Every Medical Field*, 276 J.A.M.A. 768 (1996).

42. Id.

43. Id.

44. *Kevorkian Takes Stand in Own Defense*, N.Y. Times, Apr. 28, 1994,

G. Patients' Fears of Dependence, Unremitting Pain and Loss of Dignity Are Often Exacerbated by the Practices of Managed Care Programs.

A 1996 Gallup poll, conducted for the National Hospice Organization, regarding public attitudes about assisted suicide found that, among their greatest fears about death, people fear most the prospects of dependence, pain and loss of dignity.[45] In many ways, the current practices in managed care programs operate in a manner that turns these fears into reality.

It is often chronically ill patients, particularly those who are elderly or poor, who are hardest hit by the cost containment aspects of managed care. Within HMO plans, such patients fare poorly in comparison to similar patients in fee-for-service plans.[46] Their plight may become even more pronounced in the future since these patients "account for a disproportionate share of health care expenditures and are therefore prime targets of cost containment." [47]

It is well known tnat chronic conditions can often be controlled or, at least, their progression can be slowed down if appropriate and necessary care is provided. The lack of emphasis placed on chronic care by managed care organizations can actually lead to patients' becoming dependent sooner than they would have been if appropriate care had been provided. Thus, managed care's lack of attention to chronic conditions may serve to heighten dependence which a great number of people fear and could actually lead to a greater number of people considering assisted suicide.

NOTES *(Continued)*

at A8. Dr. Stanley Levy, an internal medicine physician who specializes in geriatrics, called the activities of Jack Kevorkian "new age hospice care" while testifying for the defense during Kevorkian's trial in the death of Thomas Hyde, who died of carbon monoxide poisoning on August 4, 1993.

45. National Hospice Organization, Press Release, Oct. 3, 1996, at 2.

46. J. Ware, M. Bayliss, W. Rogers, M. Kosinski, A. Tarlov, *Difference in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 J.A.M.A. 1039 (1996).

47. Id., at 1040.

The fear of unremitting pain which causes great anxiety for patients and which some have said could lead them to seek assisted suicide is heightened due to the inaccessibility of pain control for many people. It is the lack of access, not an absence of such interventions, that creates this tragic situation. Patients are often forced to endure pain because third party payers refuse to reimburse for its treatment. In effect, "by rationing pain management on a financial basis, patients are being forced to consider death as their only option."[48]

Navigating the murky waters of services not covered, services not approved and the complex methods of co-payments is particularly difficult for patients who are in pain. They have precious little energy to deal with a system that seems to block their access to necessary pain relief at every turn.

This denial of needed pain control is most pronounced within certain categories of patients. In 1994, the State of California's "Summit on Effective Pain Management"[49] found that third party payers often restrict payment for pain-related services.[50] It further found that pain is more likely to be undertreated if the patient is a member of a minority, female, elderly, or a child.[51]

Among these groups who are undertreated, the problem of pain relief is especially difficult for the elderly. Until recently, management of pain in elderly patients was largely ignored, although findings indicate that the prevalence of pain in the elderly is known to be twice that of younger people and can be as high as eighty-five percent in older people living in

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48. K. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain and Symptom Mgmt. 289, 292 (1991).

49. In March 1994, the State of California sponsored a "Summit on Effective Pain Management" at which more than 120 health care practitioners, professional and public educators, representatives of professional schools and associations, and health care consumers met to identify and recommend solutions to legal, professional, and educational barriers to effective pain management.

50. State of California, *Report on "Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing,"* 5 (1994).

51. Id.

long-term care settings,[52] even though individualized pain management plans for older people can be highly effective.[53] The problem in a managed care context is that individualized plans are time consuming.

Nurses, in particular, have been important in providing the personalized attention needed for effective pain management plans. The nurse's role has been particularly important since it has been the nurse who has previously been able to spend the time to communicate carefully with the elderly patient so that pain control needs can be accurately assessed. Now, however, in attempts to reduce costs in the realm of managed care, many hospitals and other health facilities are cutting back on their nursing staffs and patients are finding that not only doctors, but nurses, no longer have time for them.

According to Howard Berliner, professor of health policy at the New School for Social Research, "Hospitals are under pressure from managed care to reduce costs, and they are looking at nurses as their highest-cost line item."[54] In many cases, nurses are being replaced with unlicensed aids who have neither the training nor skill required to serve as effective patient advocates.

The failure to allocate the necessary time and resources to giving adequate pain management creates the untenable situation, so greatly and rightfully feared by many people. This could well lead a patient to believe erroneously that "nothing can be done" to alleviate suffering and, in turn, this could result in a patient's choosing assisted suicide as the only available means to escape pain.

Patient concerns about loss of dignity are also heightened by the cost containment policies and requirements of managed care programs. It is difficult for patients to feel valued and

52. B. Ferrell, *Pain Management in Elderly People*, 39 J. Am. Geriatr. Soc. 64 (1991).

53. T. Fulmer, L. Mion, M. Bottrell *et al.*, *Pain Management Protocol: Inappropriate Pain Management Leaves Both the Elder and the Nurse Feeling Unfulfilled and Unhappy with the Care*, 17 Geriatr. Nurs. 222 (1996).

54. Rosenthal, *New York Hospitals Cut Costs by Laying Off Nurses*, N.Y.Times, Aug. 19, 1996.

cared for when physicians are compelled to treat them as though they were assembly line products being processed in an allotted number of minutes. This production line mentality was described by Dr. Leonard Laster, distinguished professor of medicine and health policy at the University of Massachusetts Medical Center in Worcester: "Business managers working in the interests of cost-cutting now tell doctors how much time to spend with a patient, and many allow only ten minutes for a returning patient and no more than twenty minutes for a new patient. How can anyone perform even a passable evaluation in twenty minutes on an elderly patient with a massive written clinical record. . . .?"[55]

Mandated time restrictions are not the only thing that can leave patients feeling demeaned and unimportant. Sometimes the greatest assaults on one's sense of self-worth emanate from small indignities. When one of the nation's largest managed care companies experienced losses in 1995, it instituted cost cutting measures which included the refusal to provide gowns for gynecological exam patients. Patients were told to disrobe and then, instead of being provided with a gown, they were given a small square of paper on which they were to sit while awaiting the examination.[56]

It stretches credulity to think that managed care programs — which fail to reimburse for adequate pain control, control exam times down to the minute, and deny a patient even a simple gown with which to cover herself — would allot large sums of money for comprehensive services so that assisted suicide would be used only as a last resort.

It could be assumed that, if patients are faced with demeaning and life threatening conditions such as have been described, they need only avail themselves of the appeal or complaint procedures that are in place in large corporations, including large health care corporations. However, the process of appealing a managed care program's decision is often time-consuming, costly and beyond the ability of many patients

55. Laster, *Managed Care Translates to "Let the Patient Beware,"* Am. Med. News, Feb. 19, 1996, at 18.

56. Auerbach, supra note 16.

who are already using every ounce of energy and every financial resource to exist on a daily basis. Meanwhile, as the quest for administrative remedies drags on, the patient's agony remains unrelieved.

H. The Appeals Process under Managed Care Is Often So Complex that Patients Could Consider Assisted Suicide to Be Their Only Recourse.

When essential treatment is denied, the appeals procedure under managed care is often so complex and time consuming that the accompanying delays can cause a patient grave harm. Additionally, personnel investigating the appeal may not have expertise in assessing the actual medical condition or its appropriate treatment. One such case involved a child with an extremely rare kidney tumor that is fatal if not treated but has a ninety-seven percent cure rate with prompt surgery. The child's primary care physician sought permission from the group plan to refer the child to an out-of-group specialist, since the group itself had no one with the needed expertise in treating the child's condition. The group's acting medical director, an ophthalmologist (eye specialist), refused to authorize the referral, saying that an in-group physician should perform the surgery. When the child's parents appealed, the appeal procedure was handled by a nurse who also denied the referral.

This left the family with two options: Have the surgery performed by a surgeon who was unqualified for it or personally bear the cost of an experienced medical team outside the group. Her parents opted for the latter, and the child's condition was cured. However, the managed care group not only refused to pay for the surgery but also denied any reimbursement for the accompanying hospital costs, even though these costs were identical to those that would have been incurred if an in-group physician had performed the surgery.

It took close to four years but, in October of 1996, the managed care program was fined by the California Department of Corporations for failing to provide the child "as well as all member patients with all medically necessary physician

services." It was also found that the managed care program had failed to demonstrate that its refusal to refer the child to a qualified surgeon was unhindered by fiscal and administrative considerations.[57]

Unfortunately, many people who are denied care, give up. They have neither the money to obtain care outside their managed care program nor the inclination to embark on court challenges. The outcome for such individuals could mean that a potentially fatal, yet curable, condition is allowed to progress. If assisted suicide is permitted, such individuals may well find that the same managed care organization that denied reimbursement for life-saving interventions will approve reimbursement for life-ending medication.

Obtaining necessary services through HMOs has been particularly difficult for Medicare patients. For many elderly patients, the process required for peer review of an HMO's decision to deny them care is too confusing, involves long time delays, and ultimately ends up being a useless endeavor. These facts prompted a class-action lawsuit on behalf of the millions of Medicare beneficiaries who are in HMOs.[58]

The administration and the HMO industry contended that federal Medicare law "does not require an impartial review procedure for Medicare beneficiaries enrolled in HMOs before a termination or denial of their HMO services."[59] However, U.S. District Court Judge Alfredo C. Marquez found otherwise. He stated that Medicare patients in HMOs are entitled to immediate hearings whenever they are denied medical services.[60] The need for immediacy is particularly important for Medicare patients since, "When Medicare services are denied, they are often foregone and, depending on the medical condition, final adjudication may come too late

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57. *Comm'r of Corp. v. Takecare Health Plan*, (Cal. Dept. of Corp., No. 933-0290, OAH No. N 9412060, Oct. 29, 1996).

58. Between 1987 and 1995, the number of Medicare beneficiaries covered in capitated programs almost tripled. D. Berwick, *Payment by Capitation and the Quality of Care*, 335 New Eng. J. Med. 1227 (1996).

59. Pear, *Medicare Patients in HMOs Win Case*, N.Y.Times, Oct. 31, 1996.

60. *Grijalva v. Shalala*, No. 93-711, slip op. (D. Ariz. Oct. 17, 1996).

to rectify the situation, especially if the deprivation contributed to or resulted in unnecessary pain and suffering or death."[61]

In a strongly worded opinion, Judge Marquez noted that, even though there were regulations and guidelines that should have protected Medicare beneficiaries, they were not being followed. Complex and confusing in-house review procedures amounted to little more than "a 'rubber stamp' of the initial denial,"[62] which has "grave consequences because an HMO denial may mean the enrollee will go without medically necessary service."[63] He further noted, "Given the length of time it takes for further appeal of the HMO denial, deprivations will certainly have significant impacts on quality of life and some may even be life threatening."[64]

According to Judge Marquez, an HMO often "hides the ball"[65] and frequently doesn't let Medicare patients know that they have a "right to present additional evidence to the HMO for reconsideration."[66] He concluded, as did the District of Columbia Circuit Court in *Gray Panthers v. Schweiker,*[67] "Current procedures allotted to the elderly Medicare claimant, probably disadvantaged by disability and poverty, resemble playing against a stacked deck. . . ."[68]

Yet, it is not only patients that are detrimentally affected by the manner in which managed care organizations are presently operating. The impact on the medical profession as a whole and, along with it, the increased risk to patients which may not be evident for several years must also be considered.

61. Id., at 19.
62. Id., at 23.
63. Id., at 23-24.
64. Id., at 24.
65. Id., at 22.
66. Id., at 23.
67. *Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980).
68. Id., at 172.

I. The Policies of Managed Care Corporations Compromise the Quality and Expertise of the Medical Profession, Making It Imperative that States Have the Right to Protect Residents from Assisted Suicide.

Credentialing procedures for those in the health care field are not new. For years professional organizations have established standards for credentialing physicians and other licensed independent practitioners. Historically, hospital review committees and other professional organizations examined a physician's educational background and professional competency to determine his or her ability to render appropriate medical care. With the advent of managed care, however, a new type of credentialing, known as "economic credentialing," was instituted. This type of determination about physicians' suitability to practice medicine is unrelated to the quality of care they provide or to their professional competency. Rather it is based upon economic criteria. Thus, if a physician is deemed to spend too much time with patients or found to be ordering too many diagnostic tests (even though the time and tests may have been medically appropriate), the physician risks dismissal from a health plan or physician group.[69]

Ironically, at the same time that managed care organizations have placed great emphasis on credentialing as it relates to competency in reducing costs, they have often paid far less attention to credentialing that would insure patient safety. For example, one HMO solicited physicians by mail and encouraged them to become providers within the managed care organization. The screening process for the physicians was limited to verifying that the physicians were licensed, had hospital medical staff privileges and were able to prescribe narcotics. No personal interviews and no investigations about prior medical malpractice claims were conducted.[70]

Although an increasing number of physicians are alarmed by the harmful impact of managed care upon professional practice, this may not be enough to deter young physicians,

69. See, e.g., Cal. Med. MEDFAX, (So. Cal. Ed.) Jan. 8, 1996, at 2.
70. See, e.g., *Harrell v. Total Health Care, Inc.* 781 S.W. 2d 58 (Mo. 1989).

just entering medical practice, from embracing managed care. Due to the increased competition for health care dollars and the decline of the traditional fee-for-service practice, many physicians feel compelled to contract with managed care firms out of a sense of economic survival. Since large managed care firms offer employers a reduced rate for employee health coverage, and since these firms, in turn, contract with physicians, physicians who practice in fee-for-service are being left high and dry. Thus, a young physician who is entering into practice with the burden of heavy medical school debts may find that the economic security of a managed care contract — flawed though it may be — is the only economically viable option.

Indeed, with managed care beginning to dominate the entire health care delivery system, doctors may find themselves forced to choose between practicing managed medicine or not practicing medicine at all.

III. POLICIES WHICH PUT COST CONTAINMENT AND HEALTH CARE INDUSTRY PROFITS BEFORE PATIENT WELL-BEING MAKE IT ABUNDANTLY CLEAR THAT STATES HAVE BOTH A VITAL AND A RATIONAL INTEREST IN PROTECTING THEIR RESIDENTS BY PROHIBITING ASSISTED SUICIDE.

As providers in a managed care environment, many physicians will continue to be sincerely motivated by respect for patient well-being and autonomy, but the cost factor will always lurk in the shadows. As precarious as the situation resulting from managed care is at present, it would only become worse if physician-assisted suicide were to be considered a legitimate and legal medical option. If states are not permitted to protect their citizens from assisted suicide, the managed care provider would, in many cases, become the managed death provider. Dr. Daniel Sulmasy described the link between managed care and assisted suicide in concise terms when he stated that "the movement toward managed care as a preferred means to control health care cost and the

movement toward managed death as the preferred means to control terminal suffering are strong, active and current."[71]

To gauge the accuracy of Dr. Sulmasy's warning, one need only reflect on the vise-like pressure placed on doctors that has been described above and examine what has happened when voters in the state of Oregon approved Measure 16, the "Death with Dignity Act," which permits assisted suicide under certain conditions.[72] Less than five weeks after Measure 16's passage, Oregon's Medicaid director, Jean Thorne, said that assisted suicide would be covered under a part of the Oregon Health Plan called "comfort care."[73] Noteworthy was the fact that, as assisted suicide was being scheduled as a covered service, other existing services for poor Oregonians were being scrutinized for cuts.[74]

While some may question any direct relationship between the passage of Oregon's assisted suicide measure and attempts to cut health services, the cost effectiveness of hastened death is as undeniable as gravity. The earlier a patient dies, the less costly is his or her care. In any event, dead patients do not threaten managed care profits.

Likewise, there are varied opinions about any link between cost of care and euthanasia in the Netherlands where thousands of assisted suicide and euthanasia deaths occur annually, and more than one half of those deaths are not requested by the patients who died.[75] Of note is the cost of

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71. D. Sulmasy, *Managed Care and Managed Death*, 155 Arch. Int. Med. 133 (1995). Although Sulmasy refers to managed death for "terminal suffering," it is highly unlikely that assisted suicide would or could be limited to those whose conditions are diagnosed as "terminal." See e.g., E. Chevlen, *The Limits of Prognostication*, 35 Duq. L. Rev.337 (1996); and Marker, supra note 13, at 90-94.

72. The Oregon statute was enjoined by federal district court Judge Michael Hogan the day before it was to take effect. See *Lee v. State of Oregon*, 891 F.Supp.1429 (D. Or. 1995).

73. Postrel, *State Could Cover Assisted Suicide*, Statesman Journal (Salem, OR), Dec. 1, 1994, at A1.

74. Deitz, *Lawmakers May Trim Health Plan*, Statesman Journal (Salem, OR) Jan. 9, 1995.

75. Marker, supra note 13, at 85. Although the Dutch practice of physician induced death began with the intent of offering patients greater con-

performing euthanasia in the Netherlands which, Dutch euthanasia practitioner Dr. Pieter Admiraal has explained, can be performed for about five guilders whereas the cost of a single day of hospitalization is five hundred guilders.[76] Perhaps coincidentally, perhaps not, the Netherlands has the lowest per capita health expenditure in all of Europe.[77] According to Dr. Jeffrey Jackson of the Walter Reed Army Medical Center in Washington, this low per patient expenditure "reflects an ongoing effort to ensure that Dutch physicians are sensitive to cost and practice economically prudent medicine."[78]

CONCLUSION

Managed care has been referred to as a "work in progress"[79] which may eventually work very well if improvements are made. But those improvements could take years as legislatures and courts wrestle with the complex problems and conflicts of interest inherent in managed care programs. Meanwhile, the issues before this Court demand immediate resolution.

This Court faces the momentous task of determining whether the United States Constitution precludes states from enacting statutes prohibiting assisted suicide. Proponents of a constitutional right to have a doctor actively participate in assisted suicide argue that the issue before this Court is one of individual rights. But their assertions ignore the context within which that activity would be undertaken.

NOTES *(Continued)*

trol over their own deaths, the practice of euthanasia and assisted suicide has actually increased the power and control of doctors, not patients. See generally: H. Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure* (New York: W.W. Norton & Co.1997).

76. R. Marker, *Deadly Compassion* 146 (New York: Wm. Morrow & Co. 1993).

77. Reuters Health News Service, *Lessons on Healthcare Reform from the Dutch*, July 22, 1996

78. Id.

79. P. M. Ellwood, *Managed Care: A Work in Progress*, 276 J.A.M.A. 1083 (1996).

This Court must decide the issue based not only on abstract notions of individual liberty but on the reality of the environment within which personal and medical decisions would be made. Only then can it determine whether the state laws under consideration sufficiently support valid state purposes and thus, pass constitutional scrutiny.

This brief has demonstrated that the current health care environment is evolving into a system defined by cost-cutting imperatives and dominated by a form of health insurance known generically as managed care. Further, it has shown that the very purpose of managed care, which is to reduce the cost of providing medical care, is accomplished, in large part, through a system that rewards reduced levels of care.

In such a milieu, the kind of treatment that modern medicine is capable of providing (e.g. pain control, symptom management, and treatment of depression which is often essential to patient well-being and a desire to continue living) can be difficult to obtain. This problem would be exacerbated if the less costly and less time consuming "service" of assisted suicide were available mandatorily as a constitutional right. This could well create scenarios in which agonized and depressed patients would elect to have their deaths facilitated since their relievable suffering went unalleviated because of their health providers' financial imperatives. Moreover, forcing physicians to elect between providing patients with care, at the risk of having their own incomes reduced, and suggesting assisted suicide as a cost saving measure, would place doctors in an ethical and moral conundrum. The deleterious impact of that would be felt by the medical professionals, patients, and society as a whole.

This is the reality with which the Court must grapple.

In sum, legalizing physician-assisted suicide in a health care system in which financial incentives would favor denying care and hastening death would create a profound injustice.

Rather than serving the noble cause of individual liberty, it would make a mockery of freedom, since the "choice" to commit assisted suicide would, in many cases, have essentially been predetermined by managed care's financial imperatives.

Decisions to die would often be based, not on the inability of physicians to control pain and limit suffering but on pecuniary determinations.

That being so, state legislative decisions to prohibit assisted suicide are constitutional since they serve vital and rational state interests. Such laws ensure that managed health care does not devolve into a system of managed death. They protect and reinforce the traditional ethics of the health care profession. They strengthen the bond of trust essential to the patient-physician relationship by preventing doctors from being tempted to end patients' lives in order to promote their own financial ends. Perhaps most importantly, they reinforce the essential moral concept that human beings are not commodities, that lives cannot be measured in pecuniary terms, and that rich or poor, powerful or weak, no one should be sacrificed to benefit financial bottom lines.

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